LOCAL GOVERNMENT NSW

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Dr Joe McGirr MP
Chair
Legislative Assembly Select Committee on Remote, Rural and Regional Health
NSW Parliament

Via email: remoteruralregionalhealth@parliament.nsw.gov.au

Re: Local Government NSW - Response to Questions on Notice

Dear Chair

Thank you for the opportunity for representatives of Local Government NSW (LGNSW) to appear before a 3 June 2024 hearing of the Select Committee on Remote, Rural and Regional Health inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW.

Please see below responses to three questions on notice from that hearing.

Ms JANELLE SAFFIN: My question is to either or both. Thank you for your submission. It's about recommendation 43 of the report. It said that LHDs should work with local communities and health providers, in particular, to develop place-based health needs assessment and local health plans. Have you seen that happen? Have you noticed any progress in that area, either where you live or across the State? And do regional LHDs consult with local councils, effectively or at all?

DARRIEA TURLEY: My experience is that there is a conversation happening with local councils at different levels. I can't say it is across all the local health districts. But when you're looking at those local plans, I'm not sure how they're engaging with their local health councils around that, to make sure their health councils are endorsing their plans. One of the models that NSW Health developed many years ago, which has been in situ, is around local health councils representing the community. I'm not sure if those plans go for endorsement or if staff go to the health councils and ask, "Is this information being shared with the community?" If you did a screen across the board, I

wonder how many media stories you would see of councils standing with a CEO, sharing a health plan. I just don't know if it's being implemented. I'm happy to take that as a question on notice and ask our general managers and mayors.

LGNSW sought feedback from mayors, councillors and general managers to assist with the response to this question. The feedback was mixed, indicating varied experiences of engagement with LHDs across rural and regional NSW.

A summary and extracts of some of the more positive feedback follows:

- The Mayor, General Manager and staff have regular quarterly meetings with our Southern Area Local Health Board representatives and Queanbeyan Hospital District leadership and community teams, and we support their community engagement opportunities. They share very useful information on their challenges, opportunities, patient numbers, staff and delivery of services.

- In general terms, the Murrumbidgee Local Health District (MLHD) provides a quarterly forum where the MLHD CEO provides a status update on Local Health District issues, including responses to issues raised by individual councils which provides an opportunity for all councils to remain informed. This forum appears to be reasonably well attended by Mayors and GMs from within the region covered by the MLHD.

- LHDs provide advice and updates regularly to council staff, but councillors get more limited detail in briefings. Councillors should be directly briefed by LHDs, as it relates so directly to one of the key issues residents raise with councillors as representatives of their communities.

- In respect of local health plans, several representatives of Cootamundra-Gundagai Regional Council (CGRC) have had the opportunity to participate in a Cootamundra Partnership Reference Group over the last twelve months or so, established specifically to act as a reference group for MLHD as it developed the draft Cootamundra Health Service Plan. The final draft Health Service Plan is currently on exhibition within the Cootamundra community. It is fair to say that the Partnership Reference Group provided an opportunity for a variety of stakeholders, including the representatives of CGRC, to have ongoing input and build awareness as the draft Health Service Plan was being developed, including direct briefings to the Councillors of CGRC in at least two workshops. There may be some suggestion that some input provided may not have been adequately acknowledged in the final draft however, the consultation process was arguably very reasonable overall.

- Prior to the 2021 enquiry, there was a distinct lack of effective community consultation in formulating strategic policy, including clinical services plans, with zero consultation by Hunter New England Local Health District with Council. There has been a more open channel of communication since 2021. There is a commitment to engage with respect to clinical services plan revision.

- From a Bega Valley Shire Council perspective we believe our LHD does a good job in its a approach to planning and find that they are good at engaging with us and being responsive when we want to raise issues. We have regular catch ups with key representatives and have had the LHD CEO and key staff present to our councillors periodically.

- Lockhart Shire Council is part of the Murrumbidgee Local Health District (MLHD). The CEO of the MLHD is proactive in communicating with local councils. The CEO convenes quarterly virtual meetings involving the Mayors and General Managers of all councils in the MLHD. The meetings are used to provide information on infectious diseases, current issues affecting the Health District and other health matters as well as to provide councils with the opportunity to raise issues or provide feedback. The meetings are also used to discuss matters that affect the delivery of health services in local areas such as difficulty in recruiting essential workers and availability of housing.

- Lockhart Shire Council also believes that Local Health Advisory Committees, auspiced by MLHD, provide a very good avenue for giving local communities an opportunity to have input into the delivery of health services.

- The Lockhart Local Health Advisory Committee has been very active until recently when several members became ineligible to continue serving on the committee due to protocols regarding a maximum number of terms. Due to the difficulty in attracting volunteers, it is a shame when people who are willing to volunteer their time are unable to, so this is a protocol that could be reviewed.

- For Hay Shire Council, lots of consultation and engagement is happening at the Local Health Advisory Committee level of which Council is a part. They do listen and take on board suggestions and concerns but there is a sense of a one size fits all approach and unique circumstances not always being taken into account. LHD initiatives don't seem to reach us here in Hay. E.g. overseas recruitment of nurses, nurse practitioners/generalists, the grad start program. There is a quarterly LHD catch up with Council however it is more an information sharing session rather than consultation.

- Murray River Council faced an instance in a smaller community where there was a lack of doctors available for emergencies or patient care at the local hospital.

The council engaged with the Murrumbidgee Local Health District (MLHD) multiple times to address this issue. Additionally, the council has representation on a local LHAC Committee (Local Health Advisory Committee), indicating ongoing involvement in healthcare matters.

- For Bathurst, we have noticed an improvement in engagement with the LHD in recent times, but not quite so much in recent months, possibly because the focus of engagement is around the Bathurst Hospital upgrade. That project team has engaged on occasions with Council but there is still some work to do to claim it has been truly collaborative. A Council led health advisory committee has been re-established with LHD and Bathurst Health Service representation (along with other stakeholders) which is a further example of improved dialogue. As always, more can be done but it appears to be an improving trend.

- The Nepean Blue Mountains LHD (NBM LHD) covers four Local Government Area (LGA) with very different demographic characteristics, of which the Blue Mountains LGA is one of the smaller and slower-growing regions. The 'centre of gravity' for the LHD is Penrith LGA, which houses the LHD's major hospital and is also where many health services are based. This has created some difficulties for residents at the western end of the LGA, centred around Katoomba (a major centre of population located about an hour's drive from Penrith.)

- Blue Mountains Council recently hosted a forum to bring together local services and LHD representatives to discuss key issues, particularly as pertains to complex mental health issues for families. The LHD was an active participant in this forum and showed both an awareness of the need for outreach services to the Katoomba region and a willingness to work with local stakeholders to facilitate access to needed healthcare support.

- Staff from the Child and Family Counselling unit of the NBM LHD regularly attend the Coalition Against Violence and Abuse interagency meetings in the Blue Mountains, which has been valuable in strengthening service referral knowledge and local needs, however long wait times are still experienced. There is some representation from the NBM LHD on the Youth Mental Illness and Substance Abuse interagency monthly meeting convened by Blue Mountains City Council.

- The Blue Mountains City Council Community Development Service are currently at work on a local health profile which we would like to confer with the NBM LHD on. A greater amount of consultation and collaboration with the LHD would be desirable, particularly instigated by the LHD.

However, there was also some negative feedback on consultation and engagement by Local Health Districts. A summary of this feedback is as follows.

- I have not noticed a great deal of consultation from the LHD. An indication of this was the closing down of Murwillumbah Hospital's surgical ward with no community consultation and no communication with council. This was poorly handled and caused significant distress to the staff and community.

- The LHD has limited contact with Clarence Valley Council unless about specific projects like the Grafton Hospital upgrade or environmental health compliance activities.

- The short answer is no. There are vast differences between local communities within established LHDs, almost guaranteeing that their efforts are at best dissipated and at worst ineffective. The situation is further exacerbated by distance, an ageing population, low population densities and an inability to attract and retain suitably trained medical staff. It is impossible to develop place-based health needs assessment and local health plans in areas that fail to align to any existing established boundaries by other government agencies and allied health providers, who continue to remain completely incapable of adequately coordinated service provision over boundaries - none of which align. This guarantees that the best intentions of service provision are uncoordinated and dissipated.

- Inverell Shire Council established a taskforce in April 2023, to provide strategic advice to the council on matters impacting the provision of health services in the Shire and any relevant socio-economic factors impacting the community need for health and allied services. The taskforce provides a forum for complex and strategic issues to be discussed, for expert speakers to address taskforce members, and for the taskforce to prepare advice and recommendations to the council. The taskforce meets monthly, but there has been limited Hunter New England LHD involvement to date. There has been no direct Hunter New England LHD contact with the council.

- The local staff do their best but the LHD is not effectively consulting.

Mrs TANYA THOMPSON: The PC2 report made recommendations that NSW Health, local health districts and Transport for NSW work together for more frequent and affordable transport services for people to attend medical appointments. Have any regional councils reported progress in relation to this recommendation, to your knowledge?

Public transport is often poor or absent in rural and regional areas, making travel to medical appointments or hospital visits a significant challenge. LGNSW again sought

feedback from the local government sector to inform this response, with the returned feedback demonstrating transport remains a serious barrier to accessing health services.

A selection of comments is provided below.

- Transport is diabolical in regions, especially public transport. Travel to medical appointments or hospital visits is so much harder without free patient transport. If driving, then parking poses a challenge, in terms of cost and location.

- We are hearing more and more about challenges in relation to the lack of transport options – specifically for vulnerable members of our communities, across the whole region. Small communities like Braidwood are reliant on local residents to provide volunteer services. The distance to larger towns and the small size of our community are factors which limit the effectiveness of services reliant on volunteer drivers. Road conditions also have an impact on travel time e.g. travel to Canberra at the moment is delayed by major roadworks.

- In terms of patient transport, I understand there is one additional patient transport vehicle to service Manning Hospital, Taree. To put this issue in context, if ambulance vehicles are included, their effectiveness in patient transport is hampered by queuing in the ambulance entry to the emergency department (ED) to basically monitor those being transported while the triage backlog builds in ED. That is symptomatic of ED being used by those unable to see after hours doctors and unable to meet cost of Medicare gap.

- Transport has always been an issue. Community transport can't keep up with demand with a lack of drivers particularly for afternoon appointments. The new Tweed hospital is regularly handing out taxi vouchers which would be costing the government a fortune. I would be very interested to see how much is being spent on taxis.

- There are still deficiencies in availability of many specialist services, for which our community has to travel to Canberra (a minimum 6 hour round trip).

- Recent feedback from the elderly in our community indicates navigating online registration to access transport services for healthcare is difficult.

- In the Kyogle LGA if you need to attend a medical appointment you drive yourself. You could try relying on a third party service provider but their resources are stretched well beyond the level of demand. The more populous areas may well have a number of alternative service providers however in rural LGAs (and these are quite different to regional LGAs), you are very much left to

your own devices with the result that:

  - many elderly people continue to operate motor vehicles well beyond the period when they can safely do so as there is simply no other alternative. It is highly likely that many elderly residents are unable to meet the mandatory medical licensing requirements but continue to drive as they correctly believe that viable, cost effective and convenient alternatives are simply not available.

  - accessing even the most basic medical care is challenging and in bad weather or emergencies, nearly impossible because of poor roads, lack of medical professionals, the lack of support for up-skilling nursing staff so they can perform medical procedures such as post-surgery dressing changes to operating an x-ray machine. There is ample precedent of these practices in some other areas.

- A government funded community services provider that also provides a community transport service has a presence in Lockhart. Council has not noticed any change one way or the other to the frequency of the service.

- No improvement. Members of the community in Inverell have to find their own way to treatment, often between a 3 hour to 7 hour round trip. Community transport is available for some, and others opt to drive. The community is working to try to have more specialists visit to try to alleviate some of this difficulty.

- No, we have fewer transport options than previously. Community transport is available for appointments in Armidale (1 hr 30min each way) and the NSW Trainlink Bus (3 hrs 40min each way) is an option for Tamworth appointments. Otherwise people need to find their own private transport by car.

- Many people also need to travel to Brisbane and Toowoomba for health services, yet there is no public transport. A private bus company was running buses from Glen Innes to Brisbane and Toowoomba but this ended with Covid.

- Murray River Council provides community transport services throughout its Local Government Area, funded as art of Commonwealth Home Support Program Services. This service is crucial as it often serves as the only means of transport for community members. There is a cost associated with this service, but the council has implemented a hardship policy to assist individuals for whom the cost of transport could prevent them from attending medical appointments.

- The biggest transport challenge is getting to Orange for treatments. This has been a source of dispute with the LHD for many years, Orange and Dubbo being the existing hubs of a two hub model and the LHD consistently denying a three hub model is necessary. This includes transfers by ambulance which stretches the ambulance resource on occasions. Break a bone and you are taken past Bathurst Hospital to attend Orange. Ditto all trauma, serious heart and mental health complaints. There are fears this will worsen during the Bathurst Hospital upgrade, including cancer treatment and lesser mental health treatment. Once treatment has occurred in Orange, patients have to make their own way back to Bathurst.

- Patients are given taxi vouchers but the town has very limited taxi availability, which is not always available. The patient transport service is struggling to attract workers. And the distance between Cobar and Dubbo (around 3 hours) means that the service can only stay in Dubbo for a very short period of time before it needs to return, so that the drivers do not exceed WHS driving limits.

- Access to medical services is difficult within the Blue Mountains LGA. The need to travel to access care and limited transport services present a major complication for residents trying to access healthcare. Rather than becoming more abundant and cheaper, however, transport services have remained at similar levels to past years. In view of our ageing population (22.6% of residents were aged 65+ in the 2021 census, up from 19.4% in 2016,) this is effectively a reduction of services relative to need. Furthermore, we also anticipate a reduction in services in absolute terms in the coming years, particularly accessible services.

- When asked to identify the nature of the difficulties they experience, Blue Mountains seniors were much more likely to list difficulty with getting appointments (65% of respondents, compared to 36% nationally), the distance they had to travel (35% of respondents. compared to 16% nationally) and the cost of or access to transport (11% of respondents, compared to 6% nationally.) For respondents who identified themselves as having a disability or health condition that limits their activities, difficulties due to the distance they had to travel were experienced by 47% of respondents, while 20% identified cost of or access to transport as a barrier.

- Blue Mountains train services are the most-frequently used form of public transport, accounting for almost 80% of public transport usage in 2023. Trains run infrequently, however, and often operate at crush conditions due to a high volume of tourist use. Moreover, stations are frequently located a long distance from residences and present accessibility issues such as large gaps between the train and platform.

- No Blue Mountains bus services operate along the full length of the Great Western Highway in the Blue Mountains, meaning they offer less than desirable connectivity to the local hospitals and centres of healthcare provision. The current frequencies and hours of service within the Blue Mountains means buses are not competitive with other forms of transport; they accounted for only 20% of public transport trips in 2023.

- The cost of regularly taking a taxi to a medical service located perhaps an hours' drive away is financially out of reach for many residents. Furthermore, for those who need an accessible option, taxis are increasingly not available. Of the two accessible taxi services in the Blue Mountains, one has recently closed its doors and the other is due to cease operations shortly due to inability to keep up with demand.

- A community transport service [redacted] provides some options for older people, people living with a disability or other barriers to transport. Generally, users must be assessed and registered with My Aged Care or the NDIS. The service provided approximately 10,500 trips within the Blue Mountains LGA in the 2021-22 financial year, 49% of which were undertaken for medical reasons. While an invaluable option, this community transport service is the only service of its kind operating within the LGA and has not increased its capacity significantly since the 2017-18 financial year. In fact, the service reports a dwindling volunteer base post-covid which is leading to a reduction in its ability to offer the service. The accessible transports used by the service are also not large enough to accommodate certain mechanised wheelchairs.

Ms LIZA BUTLER: My question is to Councillor Turley. You spoke about supported home-based services. Could you expand on that and maybe give an example so I can fully understand that scenario?

The transition from the Commonwealth Home Support Program (CHSP) to the Support at Home Program presents several issues and challenges for NSW local councils. The transition is anticipated to take place in 2027.

The existing CHSP provides Australian Government funding directly to providers (including many councils) through grant agreements, and these providers then deliver subsidised services to older people. The new Support at Home program arrangements mean that providers will primarily be paid on a fee-for-service basis after a service has been delivered. This will result in less certainty for providers.

Key concerns are:

1. Funding and Budgeting

- **Uncertainty of Funding Levels:** Local councils are concerned about the potential changes in funding allocations. The CHSP provided block funding, which allowed councils to plan services with some certainty. The new model may alter funding structures, potentially leading to uncertainty and instability.

- **Transition Costs:** Councils may incur additional costs during the transition period, including administrative expenses, staff training, and system upgrades.

2. Service Delivery and Continuity

- **Service Disruption:** There is a risk of service disruption during the transition, which could negatively impact elderly residents who rely on consistent support services.

- **Adaptation to New Models:** Councils will need to adapt to new service delivery models, which may require significant changes in how services are planned and delivered.

3. Workforce and Training

- **Staff Training:** Staff may need training to adapt to new policies, procedures, and service delivery models under the Support at Home Program, potentially increasing costs for councils.

- **Retention and Recruitment:** Ensuring that skilled workers are retained and that recruitment processes align with the new program requirements can be challenging.

4. Administrative and System Changes

- **System Integration:** Councils will need to integrate new systems for service delivery, reporting, and client management. This may involve significant IT upgrades and changes to existing processes.

- **Administrative Burden:** The transition may increase the administrative workload initially, as councils manage the changeover and align with new reporting and compliance requirements.

5. Client Impact and Communication

- **Client Confusion:** Elderly clients and their families may be confused about the changes, requiring councils to invest time and resources in effective communication and support during the transition.

- **Individualized Service Planning:** The Support at Home Program may emphasize individualized service plans, requiring councils to spend more time and money on assessments and personalized service design.

6. Regulatory and Compliance Challenges

- **Alignment with New Regulations:** Councils will need to ensure compliance with new regulatory requirements, which may differ from the existing CHSP guidelines.

- **Quality Assurance:** Maintaining high standards of service quality during the transition is critical but challenging, particularly with potential changes in service models and funding mechanisms.

7. Strategic and Operational Planning

- **Strategic Alignment:** Councils will need to align their strategic plans with the objectives and framework of the Support at Home Program, which may differ from the CHSP.

- **Operational Readiness:** Ensuring that all operational aspects, from staffing to service delivery processes, are ready for the transition is a multi-faceted task and may require input from several divisions of councils.

8. Community and Stakeholder Engagement

- **Engaging Stakeholders:** Effective engagement with stakeholders, including service users, carers, and local community organizations, is crucial to ensure a smooth transition and buy-in from all parties involved.

- **Building Partnerships:** Collaborating and developing partnerships with other service providers and organizations may be necessary to deliver comprehensive support under the new program.

9. Monitoring and Evaluation

- **Performance Monitoring:** Establishing new and appropriate performance monitoring and evaluation frameworks to measure the effectiveness of services under the Support at Home Program.

- **Feedback Mechanisms:** Implementing robust feedback mechanisms to gather input from clients and stakeholders during and after the transition.

Addressing these issues will require careful planning, resource allocation, and proactive management to ensure that the transition to the Support at Home Program is as smooth as possible for both service providers and recipients. Some councils may require support and resourcing to do this effectively, and some may identify that the new funding model means it is not financially viable to continue.

Thank you again for the opportunity to contribute to this inquiry. For further information, the committee is welcome to contact LGNSW Director Advocacy Damian Thomas at 02 9242 4063 or at damian.thomas@lgnsw.org.au.

Yours sincerely

Cr Darriea Turley AM
President LGNSW